

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4719	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2011

NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTHCARE- WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the annual Licensure and Complaint #27298, conducted on January 18, through January 20, 2011, at Hillcrest West, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities	TITLE	(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		
DATE FORM	6899 T7ZB11	If continuation sheet 1 of 1